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Clinical Ethics Credentialing and the Perilous Cart-before-the-Horse Problem

A. Fiester

In the zeal to find a workable credentialing process for clinical ethics consultants, the current motto in the field seems to be “something is better than nothing.” Although the field has been talking about certification and accreditation for quite some time, the current rash of proposals seem oddly done in haste, with neither the proper vetting nor the critical scrutiny that such a high-stakes endeavor warrants. Driven, perhaps, by the pressures pent up from this feeling long overdue or, less nobly, from the threat of someone else beating the field’s insiders to the finish line, we now seem to be careening wildly towards launching something – anything– no matter how precipitate or premature. The newly announced “quality attestation” proposal (Kodish, Fins, et al 2013) seems to be a disconcerting example of a rough work-in-progress granted the status of a *fait accompli*.

And now the latest cart-before-the-horse problem can be seen in the proposal for a written examination (White, Jankowski, Shelton 2014) to assess the mastery of the topic areas of the ASBH Core Knowledge Competencies (ASBH 2011). Parallel to the other proposed elements of clinical ethics credentialing, a written examination sounds deceptively straightforward. Like the authors, one might reason: if there are specific knowledge content areas – such as “Moral reasoning and ethical theory,” “Common bioethics issues and concepts,” and “Relevant codes of ethics and professional conduct” (ASBH 2011) – then how hard could it be to create an exam that tests that knowledge? The answer is: “Harder than it looks,” as scrutinizing their mock exam questions will show. Like the new “quality attestation” proposal, the written exam does not seem quite ready for prime-time.

Let's start with the most skeptical worry about a written exam being part of the credentialing process: namely, is it even possible to write meaningful multiple choice questions in topic areas such as "Moral reasoning and ethical theory" that avoids a reductionism that makes the questions worthless? Is it possible – even in principle – to test anything useful about ethical theory in this way? Philosophy professors limit multiple choice questions to assessing whether young undergraduates have done the course reading – not to determine whether students can employ these insights in anything like the consequential applications needed for CECs. The over-simplification needed to boil down a complex philosophical idea or framework into a testable one-sentence synopsis masks or destroys the insight that made the idea valuable in the first place. Take as an example of this problem Q19: "The principle of 'double effect' means..." for which, I am guessing, the correct answer is "C: An action or treatment is ethically permissible even though it has both a good and a bad effect because there is intent is [sic] to cause the good effect" (White, Jankowski, Shelton 2014). Neither the distinction between bad effects that are intended versus those that are merely foreseen nor the idea of harm as an unavoidable side effect of pursuing a good end is captured in this pithy summary. And even selecting this cryptic answer doesn't ensure that a student knows enough about the way in which the Doctrine of Double Effect works to correctly apply the concept in CECs. As stated in answer C., this principle seems to justify both clinical negligence and malpractice as long as it is well-intentioned. For example, by this version of the Doctrine of Double Effect it is ethically permissible to operate without washing my hands because I intend the good effect of removing a cancerous growth, although the patient dies of an infection from my dirty hands. If it is possible to encompass a richer, more accurate sense of this principle, and others like it, into a multiple choice question, it hasn't been demonstrated in this mock exam.

Other problems with the test abound. It rewards shallow, superficial familiarity with concepts and issues, rather than any in-depth understanding or mastery. Take Q2, in which students are asked to select which of the four answers demonstrate “a deontological analysis.” Because the word “duty” appears in answer C., I am – again – guessing that this is the correct answer, but as a card-carrying deontologist of the Kantian stripe, I could easily name the principles that anchor A. and D., and I hope any student who has studied the theory could as well (Fiester 2007). The right answer appears to be correct merely because it employs the term “duty,” but if the student isn’t agonizing over the offered alternative answers, s/he doesn’t really understand the way in which deontology functions.

Then there is the problem that some questions don’t seem to test anything that is actually relevant to CECs. For example, Q6 asks students to identify the code of ethics that first addressed the treatment of research subjects. How is knowledge about the Nuremberg Code or the Declaration of Helsinki helpful in determining which individuals are competent to conduct clinical ethics consults?

Other questions might be getting at something important for CECs, but the examinee doesn’t need any expertise or clinical ethics competence to answer them. Look, for example, at Q12: “Which character trait is generally considered to be important for success as a clinical ethics consultant according to the American Society of Bioethics and Humanities (ASBH) guidelines?” By a process of elimination, the answer has to be B., “The ability to emphasize with others.” Answers A. and C. aren’t character traits (“A strong sense of spirituality” and “Identifying the right answer when they hear it,” respectively), and D. is downright implausible (“Willingness to take risks”). And it is worth noting that even if a student gets the test question

right, it doesn't mean that s/he actually *possesses* the trait, only that s/he knows that one *ought* to possess it.

Some questions are flawed for more worrisome reasons: i.e., they presuppose, and thereby endorse, clear-cut answers to matters that are nuanced or context-dependent, rely on judgment, or have more than one "right" answer. This can be seen in Q20: "From the options listed below, to begin mediation at this meeting you would..." Mediation doesn't function by a fixed or rigid protocol, so what a good mediator would do in any given situation depends on the situation, the mediator's style, who is at the table, how factious or contentious the conflict is, the source of the conflict, the goals and interests of the stakeholders, etc. (Bergman 2013; Dubler and Liebman 2011; Fiester 2012a; Fiester 2012b; Fiester 2013; Fiester 2014). Should the mediator "Give each person the opportunity to speak uninterrupted," "Discuss why they are so angry at each other," "Ask each person what they understand would be best for Mrs. A"? The answer is: it depends.

A second illustration of this troubling concern is Q9: "Surrogate motherhood is most criticized because it..." Assuming there is one argument against surrogate motherhood that is far more often employed than others, why would it be important for a student to know that fact? What is the question actually testing or implying? Is it that clinical ethics consultants should know the frequency with which particular arguments are advanced in bioethical debate? If so, why? Or is it that the question presupposes that "most criticized" is the equivalent to "most powerful"? All four of the choices offered seem powerful to me. Wouldn't we have more confidence in the competence of the clinical ethicist who could explain the rationale behind all *four* of the arguments presented?

The obvious rebuttal to this entire line of critique is that it misses the forest for the trees. One could argue that my criticism is so bogged down in a nitpicky assessment of the sample questions that it misses the larger point that there ought to be a written exam at all, *whatever the content of the questions*. On this objection, the authors could defend their proposal by saying that the first step is to agree in principle that there ought to be an exam, and then we can decide the content of the questions later.

My response is that these two issues cannot be separated: if it isn't possible to create a *good* exam that accurately tests clinical ethics competence, then whether or not written exams are good in theory is irrelevant. And the prospects for creating a good exam are grim if the samples in an argument advocating written exams are almost universally problematic.

All of this is to say that there is much that needs to be debated and improved in the various proposals for certification – including this one for a written exam – before there can be any confidence that they won't do more harm than good. At this point, the proposals run the risk of being incapable of weeding out those who aren't competent to perform consults, awarding consultants a spurious imprimatur based on seriously flawed assessments, providing institutions with a false sense of security that their consultants are qualified when they may not be, and failing to identify the individuals who do have the appropriate skill set to perform CECs.

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